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The National Healthy School Standard

**The development of the Cheshire health and
education partnership: a case study**

Miranda Thurston

October 2002

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Abbreviations

DfEE	Department for Education and Employment
DoH	Department of Health
EAZ	Education Action Zone
ENHPS	European Network of Health Promoting Schools
NHSS	National Healthy School Standard
PCG	Primary Care Group
PCT	Primary Care Trust
PSHCE	Personal, social, health and citizenship education
SALT	Support and Access for Teachers
WHO	World Health Organisation

Summary

Background

Since the early 1990s there has been an increasing emphasis on the school as a key 'setting' for promoting health. In part, this reflects earlier and well-established ideas about the potential of schools to influence positively the health and lifestyles of children and young people. However, more recently there has been an emphasis in policy documents on the evidence that suggests that *healthy* children and young people are more likely to achieve their academic potential, that is, that educational outcomes are closely associated with health status (St. Leger, 2000). Thus, recent Government policy documents articulate the view that schools will be helped to become 'healthy schools' (DoH, 1999). Currently, the main vehicle for facilitating this is the National Healthy School Standard (NHSS), announced jointly by the Department of Health and the then Department for Education and Employment in 1998. The scheme sought to address concerns about the quality of local healthy schools programmes and their variation across the country.

Partnership working between health and education at the local level is a key requirement of the NHSS scheme and the provision of evidence to demonstrate that this has underpinned the development of the local programme is integral to the accreditation process (DfEE, 1999). However, research from the 1970s, as well as more recent work from the late 1990s, indicates that working in partnership is frequently time consuming, problematic and with little evidence of productive outcomes (Audit Commission, 1998).

Research question

In consultation with the commissioning organisation, an overarching research question was developed, which reflected the overall purpose and focus of the study.

- What is the evidence that the Cheshire healthy schools programme is a 'partnership' based in health and education?

In order to generate evidence that could be used to help answer this question, two aims were identified:

- to describe the development of the 'partnership' and progress towards objectives, including key 'achievements';

-
- to explore perceptions of the experience of 'partnership working' using key informants from across the health and education sectors.

A case study approach was adopted, which used a combination of non-participant observation of strategic (steering group) and operational (locality group) meetings and semi-structured interviews with 'key informants' involved in the development of the local programme.

Key findings

The 'maturation' of the partnership over an eighteen-month period was described in terms of five phases. The model identifies phases of work associated with the development of partnership arrangements over time:

- Phase 1 Setting things up: developing the partnership.
- Phase 2 Developing the process for engaging schools.
- Phase 3 Developing support for schools.
- Phase 4 Rolling out the programme: working in partnership.
- Phase 5 Moving towards accreditation.

Thematic analysis of the interview transcripts provided insight into the processes that facilitated or enabled the partnership to function and move towards its agreed objectives. Overall, the partnership was perceived to have generated commitment to a common vision. The NHSS initiative was seen to have provided opportunities for better co-ordinating healthy schools work at strategic and operational levels, as well enabling schools to innovate and 'make a difference'. The consensus was that the partnership had developed a valuable framework for engaging with schools and that this was an important vehicle for ensuring a 'quality standard' across a large and diverse county. A number of factors were identified by interviewees as important in establishing and developing the partnership. For example, a history of working together and a predisposition to working with schools empathetically were identified as positive influences on partnership work. A number of 'contextual factors' were identified as militating against partnership working, for example, the magnitude and pace of change in the health and education systems and the impact this had on staff availability and continuity. At different stages in the maturity of the partnership, interviewees identified issues that caused tension, for example the lead organisation and processes of communication and decision making. Mobilising the capacity and capability of school nurses across the county and the role of outside agencies within schools continued to be debated.

Conclusion

The Cheshire health and education partnership has many of the features of the simplest and least formal model of partnership working: a steering group without *dedicated* staff and resources. In this arrangement, the work of the partnership is progressed by the partner organisations as part of their mainstream work. Some of the disadvantages of this model - such as the extent to which additional work can be accommodated within existing programmes of work when there are limited resources - were evident in interviewees' narratives. However, the NHSS can be described as a vehicle for innovation and change in some schools in Cheshire. On the other hand, it remains to be seen whether or not schools become healthy schools in a manner that leads to improved health and educational outcomes for children and young people. What can be said is that the local programme has been established in such a way that health and educational outcomes are being supported actively through the joint work of the health and education sectors at strategic and operational levels. To this extent then, it is possible to conclude that the Cheshire healthy schools programme is a partnership based in health and education.

Chapter 1

Introduction

1.1 Preface

This chapter provides an introduction to, and overview of, the research project. The purposes and aims of the project are briefly contextualised in terms of the national policy context relating to healthy schools – a key driver for commissioning the research. Additionally, a description of the county of Cheshire is given to provide a backdrop to understanding the context within which the Cheshire healthy schools partnership developed.

1.2 The National Healthy School Standard

The idea of the school as a setting for promoting the health of children and young people has a long history dating back to the beginning of the 20th Century (Beattie, 1996). Within the last five years however, debates concerning the relationship between health and educational achievement, as well as the role of the school in promoting health, have gathered momentum. This is reflected in the Government White Papers *Excellence in Schools* (DfEE, 1997) and *Saving Lives: Our Healthier Nation* (DoH, 1999), both of which explicitly identify the school as an important 'setting' for improving the health of children and young people, and, in so doing, enhancing their educational achievement. In 1998, the National Healthy School Standard (NHSS) was announced jointly by the Department of Health and the then Department for Education and Employment. The NHSS scheme provides a framework within which local programmes, based on a partnership between health and education, can develop and achieve accreditation. The accreditation process is central to the NHSS scheme and is described as giving 'credibility and status' to local programmes (DfEE, 1999, p. 2) as well as ensuring 'a consistent, high quality standard among those earning accreditation (Rivers et al, 2000, p. 6). In this respect the NHSS scheme sought to address earlier concerns about the quality of local programmes and their variation across the country.

Partnership working between health and education at the local level is a key requirement of the NHSS scheme. Furthermore, the provision of evidence to demonstrate that this has underpinned the development of the local programme at strategic and operational levels, and in relation to planning, management and

delivery, is integral to the accreditation process (DfEE, 1999). It is within this context that this study was commissioned and undertaken.

1.3 The local context

Cheshire is a large county situated in the north west of England, with a population of approximately 670,000¹. There are 352 schools in the county. Minority ethnic groups comprise less than 1 percent of the population (0.9%). It is the 15th largest authority in England and Wales. In terms of economic prosperity, it is a diverse county. There are large areas of affluence, particularly in some rural parts of the county. However, within both rural and urban areas there are populations that experience significant isolation and deprivation, which themselves generate significant education and health inequalities. In part, this is reflected in the presence, at a local level, of a number of national initiatives designed to address such inequalities. For example, the county has one education action zone (EAZ) in Ellesmere Port and three Sure Start projects. At the time the research was conducted, one health authority and six NHS Trusts served the county. During 2000-2001 there were considerable changes taking place in the health sector. Six Primary Care Groups (PCGs) were established as sub-committees of the health authority. The PCGs, together with the existing acute and community NHS trusts, were preparing for further restructuring in 2002. This time period was also characterised by considerable activity in the national policy arena as it related to health, social care and education, with an overall emphasis on 'joint working'. In particular, there were a number of initiatives that related to children and young people; for example, the Children's Fund and the Connexions Service.

Prior to the introduction of the NHSS there was some variation across the county in terms of the take up of the health promoting school programme. In the east around Macclesfield, led by the local NHS Trust, the programme was a formal part of the work of the health promotion service in collaboration with the school nursing service. Additionally, anecdotal evidence suggested that there was considerable experience of the health and education sectors working together in schools throughout the county.

¹ All information taken from www.cheshire.gov.uk website accessed 16th April 2002.

1.4 Rationale for the research

The decision to commission a piece of research to explore the development of the health and education partnership in Cheshire, within the context of the NHSS, was made in December 1999, with the research project starting in January 2000. The purpose of the research was to provide evidence for the accreditation process as well as to inform the future development of the programme.

1.5 The aims of the research

In consultation with the commissioning organisation, an overarching research question was developed, which reflected the overall purpose and focus of the study.

- What is the evidence that the Cheshire healthy schools programme is a 'partnership' based in health and education?

In order to generate evidence that could be used to help answer this question, two aims were identified:

- to describe the development of the 'partnership' and progress towards objectives, including key 'achievements';
- to explore perceptions of the experience of 'partnership working' using key informants from across the health and education sectors.

A first step in the research process was to consider the literature in the field of partnership working, particularly in terms of seeking to identify the factors and contexts within which such working does or does not take place. Key findings from the literature are explored in the following chapter and provide a framework within which the research project can be located and understood.

Chapter 2

Background and literature review

Partnership working: policy and practice

2.1 Introduction

The purpose of this chapter is twofold. Firstly, the relevant national policy context as it relates to partnership work is explored. Consideration is also given to the nature of partnership working at both a conceptual and practical level. In relation to this, the development of the healthy schools programme in general, and the National Healthy School Standard scheme in particular, is explored. Research findings that illuminate the nature and extent of partnership work within healthy schools programmes are also examined. It is intended that together, these provide a relevant backdrop to the empirical research, as well as providing a context and framework within which to make sense of the findings.

2.2 Partnership working as a theme of government policy

A number of authors have pointed out that 'joint working' has long been a theme of Government policy in respect of health and social care (see for example, Exworthy and Peckham, 1999; Glendenning, 2002; Hudson, 1999). Terminology has however varied, for example, 'inter/multi-agency working', 'collaboration', 'inter-professional working', 'multidisciplinary teamwork', 'joint working' and 'alliances', have been used at different times since the 1970s to describe various kinds of relationships that cross areas of service provision. The *idea* of working together in this way is therefore, not new, although the terminology of 'partnership working' is perhaps a more recent invention associated with the new Labour Government (see for example, DOH, 1998; Acheson, 1998). Furthermore, as Hudson (1999) and others (Charlesworth, 2001; Glendenning, 2002) have pointed out, the Labour Government is now placing a heavy premium on 'partnership working' in that it has become a *requirement* in many policy areas. Thus, the Government is placing statutory duties on local agencies to work together in areas such as health improvement (Audit Commission, 1998). In this respect partnership working has become a key vehicle for the restructuring of 'organizational responses to individual, family and community problems' (Statham, 2000, p. 87).

Partnership work between the health and education sectors has only more recently been an explicit feature of government policy. The potential for schools to contribute to the health of children and young people has, however, long been a feature of government policy documents. Since the early 1990s there has been an increasing emphasis on the school as a key 'setting' for promoting health. In part, this reflects earlier and well-established ideas about the potential of schools to influence positively the health and lifestyles of children and young people. However, more recently there has been an emphasis in policy documents on the evidence that suggests that *healthy* children and young people are more likely to achieve their academic potential, that is, that educational outcomes are closely associated with health status (St. Leger, 2000). Thus, as Rivers et al (2000, p.5) point out, there is 'a reciprocal and potentially synergistic relationship between educational and health goals'. This point is reflected in recent Government documents such as the White Papers *Excellence in Schools* (DfEE, 1997) and *Saving Lives: Our Healthier Nation* (DoH, 1999), both of which make explicit reference to the centrality of the school as a key setting for improving health and educational outcomes. This appears to be central to the rationale for partnership work between the health and education sectors in the school setting.

Within the field of health promotion, the concept of 'multisectoral action' was debated as long ago as the early 1980s by the World Health Organisation (Milio, 1986; WHO, 1986). The WHO specifically stated that 'health equity' required the concerted action and collaboration of all policy sectors, including education. In specific terms, one of the manifestations of the WHO's work in this area has been the development of the European Network of Health Promoting Schools (ENHPS), described as a 'settings based approach', launched in Europe in 1991 and joined by the UK in 1993 (Jamieson et al 1998; Barnekow Rasmussen and Rivett, 2000). The Department of Health made reference to the initiative in the 1992 White Paper, *The Health of the Nation* (DoH, 1992) and the 1999 White Paper, *Our Healthier Nation - a Contract for Health* (DoH, 1999). A set of criteria for health promoting schools was developed, two of which were concerned with the collaborative dimension to the initiative:

'realisation of the potential of specialist services in the community for advice and support in health education; development of the education potential of school health services beyond routine screening and towards active support for the curriculum.' (Jamieson et al 1998, p. 15).

The current policy vehicle for developing healthy schools work is the National Healthy School Standard (NHSS), announced jointly by the then Department for Education and Employment and the Department of Health, in May 1998. The development of the 'quality standards' (DfEE, 1999) has been informed by an external evaluation of healthy schools pilot sites, the main aim of which was to identify the core features that contribute to effective work in schools (DfEE, 1999). The resulting national standards have three sections - partnerships, programme management and working with schools - and within each of these there are a number of components, which 'provide an indication of the range of activities a local programme needs to engage in to achieve that particular standard' (DfEE, 1999). For example, section 1 on partnerships, identifies standards for the local programme such that it must:

- be based in an established education and health partnership;
- involve school staff and young people in planning;
- involve a range of agencies - statutory and non-statutory - in the planning, delivery and evaluation of activities.

The main purpose of the Standard was to address the considerable variation in local healthy schools programmes in terms of content, breadth and style that had been noted (Sinkler and Toft, 2000) as well as inconsistencies in coverage and quality (Denman, 1999). The scheme involves a formal accreditation process in which programmes are *required* to demonstrate the partnership basis - specifically between health and education - of their local programmes. From the point of view of individual schools, they are required to work within the framework of the local programme. However, there is capacity within this for the school to identify its own priorities, with reference to the national and local standards, and in collaboration with the local programme co-ordinator (DfEE, 1999).

Thus, partnership working is a theme that is woven into all three sections of the NHSS. In terms of the local programme, partnership working must be evidenced at both a strategic and operational level, in relation to:

- planning;
- management;
- delivery.

2.3 Definitions and models of partnership working

Glendenning (2002, p. 115) suggests that partnership is a 'vague concept, capable of many interpretations'. This is perhaps reflected in the multiplicity of terms used, almost interchangeably, to describe 'joint work'. However, Glendenning proposes a 'minimal definition' in order to differentiate it from other forms of relationships that organisations enter into, such as contractual ones:

'A minimal definition ... understands partnerships between organisations, groups or agencies as denoting a particular type of relationship in which one or more common goals, interests and/or dependencies are identified, acknowledged and acted upon, but in which the autonomy and separate accountabilities of the partnership organisations can remain largely untouched.' (Glendenning, 2002, p. 118)

This puts the emphasis on *formal* ways of working, in which partnership arrangements are developed that go beyond the informal and 'routinized' working styles of individuals and interactions that have become established over recent years (Webb, 1991). Statham (2000) argues that it is this that distinguishes current discourses on partnership working.

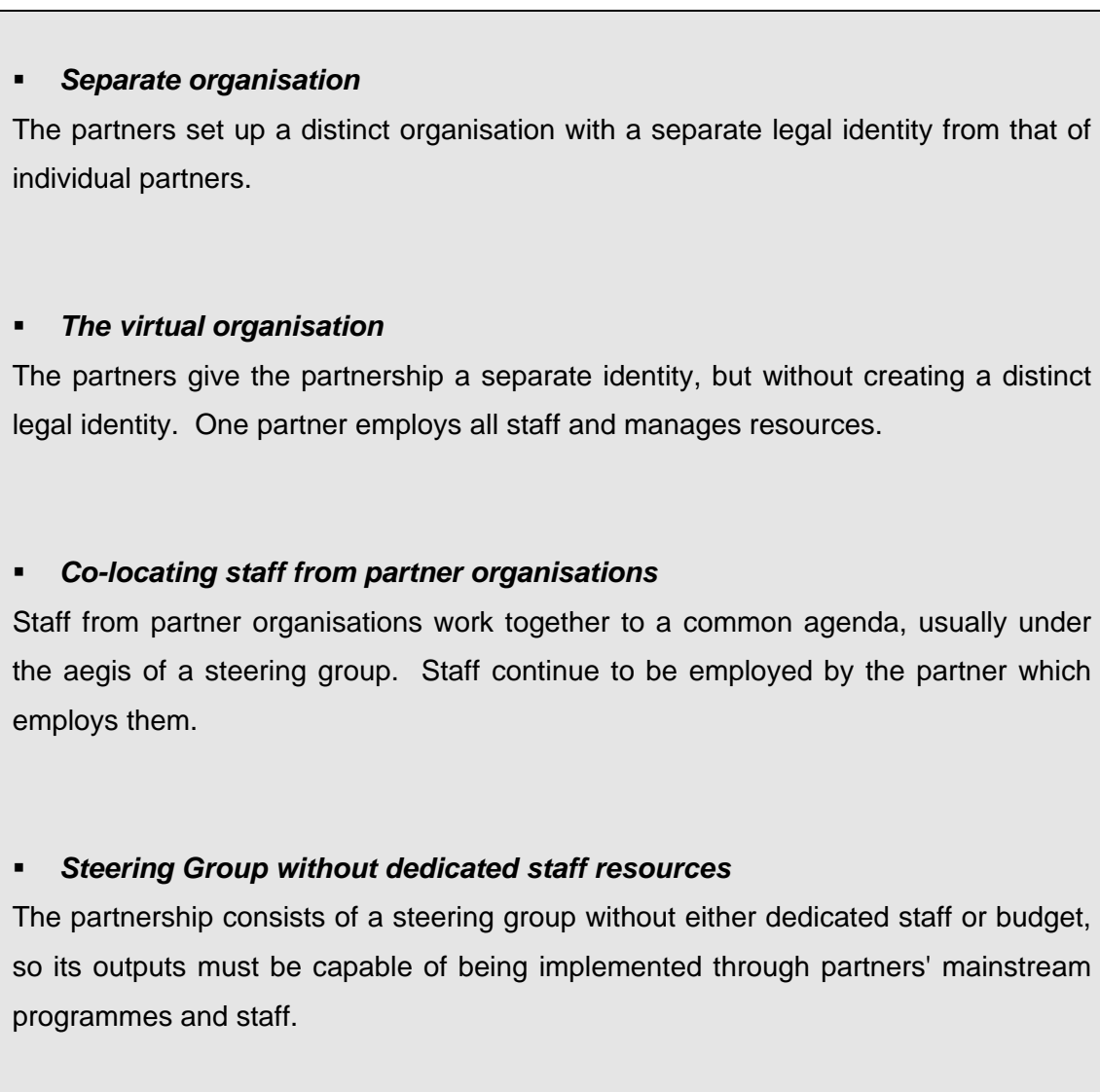
The point to be made at this juncture is not to seek to propose a definition of partnership working but rather to draw attention to the multiple meanings that might be attached to the term by those working within partnerships at both macro (strategic) and micro (operational) levels. This has resonance for research that seeks to explore partnership working in the field.

All the terms identified above have at their core an underpinning set of assumptions and values. Firstly, there is the assumption that complex problems necessitate the concerted efforts of a range of organisations, professions and agencies (Hudson, 1999; Gilmore, 2001; Statham, 2000). As a number of authors have pointed out, also central to the idea is the assumption that working together will achieve a greater degree of vertical and horizontal co-ordination and integration in respect of policy, strategy and delivery (Gray, 1985; Higgins, 1993; Hudson, 1987; Hudson, 1989; Hudson, 1999; Webb, 1991). Hudson (1987) argues that effective collaboration is dependent on not just individuals but 'interlocking organisations'. In turn, it is greater co-ordination that is seen as providing the route to better quality provision. Also implicit within the rhetoric of partnership working are notions concerned with its desirability and unproblematic nature. However, there is now considerable empirical

evidence to suggest that ‘the path to partnership does not always run smoothly’ (Charlesworth, 2001, p.283) and Gray (1985) suggests that ‘mandated collaboration’ is likely to fail. Some of the findings from this research are briefly outlined below in section 2.4.

There have been attempts to represent partnership arrangements in the form of descriptive models. For example, the Audit Commission (1998) has outlined four models, based on empirical evidence, and these are illustrated in Figure 2.3.1 below. It is evident from this typology that each model will be underpinned by different definitions, values and assumptions and that, moreover, will have different advantages and disadvantages, which will not be explored further at this juncture.

Figure 2.3.1 Models of partnership arrangements



2.4 The reality of partnership working

Research from the 1970s, as well as more recent work from the late 1990s, indicates that working in partnership is frequently time consuming, problematic and with little evidence of productive outcomes (Audit Commission, 1998). For example, a number of authors have pointed to the tensions created by differences in organisational, cultural, professional and ideological characteristics of particular contexts (Glendenning, 2002; Gray, 1985; Higgins et al, 1994; Hudson, 1999; Trowler, 1997). Gray (1985) has also suggested that partnership work is best viewed as a process, the corollary of which is that it may work better at some times than at others, depending on the maturity of the partnership as well as other circumstances. Even though the policy context requires collaboration, evidence suggests that organisations, typically strive to maintain their autonomy (Hudson, 1989), and this may also be true of professional groups. Thus, demonstrating interdependence is frequently seen as a fundamental prerequisite for effective collaboration (Gray, 1985; Hudson, 1999). However, Webb (1991) points out that it is unhelpful to treat all interactions between organisations as equally important to both. Evidence suggests that it is likely that these inclinations are more likely in a climate of organisational change, in part, because of the uncertainty generated in such environments (Fullan, 1991).

More recently (and somewhat paradoxically given the Government's pronouncements on collaboration) Charlesworth (2001) found that the scale and pace of change within the health sector was making collaboration difficult. This was both in terms of finding time, as well as justifying it as an activity if it was not perceived to be an organisation's 'core' business. Hudson (2000) also found that interagency work was threatened by individuals' anxieties about increases in workloads. Higgins et al (1994) and Statham (2000) also suggest that collaboration in a context of continuous change is unlikely, perhaps in part, because, as Plamping et al (2000) suggest, local agencies may be experiencing 'partnership fatigue'.

Two other inter-related issues have been identified by research in the area. Firstly, evidence suggests that effective partnership work is more likely where there is a history of such work (Charlesworth, 2001; Hudson, 1999; Webb, 1991). Gray (1985) argues that ideas about 'legitimacy' to be involved as a stakeholder are also influenced by history and experience. Related to this is the matter of trust between partners, often described as a precondition for collaboration (Gray, 1985; Hudson, 1999; Hudson, 2000; Webb, 1991) and seen to be generated by shared experiences

over time. Trust, or 'principled conduct' as Webb (1991) describes it, is seen as underpinning the microdynamics of collaboration. This places centre stage the role of, and opportunities for, discussion and debate as vehicles for engendering an atmosphere of trust. It is also through such interactions that a shared vision, clarity of purposes and responsibilities - also demonstrated to be important in collaborative work - can be developed (Audit Commission, 1998; Higgins et al, 1994; Hudson, 1999).

The research identified above indicates that trust, respect, commitment and legitimacy are important in collaborative work at both a micro and macro levels. However, evidence suggests that partnership work is often progressed via networks of individuals (micro) rather than interlocking organisations (macro) (Hudson, 1987; Hudson, 1999). Statham (2000) has argued that this is a shaky foundation for collaboration given that key personnel may change, a matter that is all the more likely in a context of change. Hudson (1987) argues that facilitating structures at both a strategic and an operational level are required to engage organisations in collaborative processes. On this analysis, a steering group with appropriate representation and leadership would appear to be central to the process.

Much of what has been said so far relates to research that has been conducted on collaboration between the health and social care sectors. However, the following discussion aims to throw some light on what is currently known about the nature of partnership working between the health and education sectors.

Evidence from the evaluation project of the European Network of Health Promoting Schools (ENHPS) (Jamieson et al, 1998) indicates that contact with professionals and services outwith the school tended to be limited to advice and support. Green and Tones (2000) conclude that the types of activities described by Jamieson et al did not amount to 'collaboration' as such. Yet there is also evidence to suggest that schools report a number of obstacles to becoming health promoting settings, such as lack of time; attitudes of teachers; lack of expertise; lack of external support; and, lack of resources (Thomas and Keirle, 2001). This suggests that there is a potentially synergistic relationship to be developed between the health and education sector that could be exploited by current initiatives such as the NHSS. St. Leger (2001), for example, suggests that there is substantial overlap between the successful components of a health promoting school and an effective school. However, Green and Tones point out that:

‘It is probably true to say that, for many schools in England, this represents the most problematic area for progress and the one that is least compatible with conventional views about the primary purpose of education.’ (Green and Tones, 2000, p. 2).

Collaboration between schools and primary care has been found to be comparatively rare to date (Green and Tones, 2000). However, one area where there is fairly well established collaboration is between NHS health promotion services and schools. In part, this is because such NHS units normally have a formal stated objective to work with schools (Delaney and Moran, 1991). A national survey undertaken by Scriven (1995) demonstrated that 98% of health promotion units have ‘alliances’ with the education sector, normally with respect to a single local education authority, and many are of an informal nature. Health promotion units reported that they were responsible for the initiation and management of such alliances, with the education sector playing a ‘less active role’ (Scriven, 1995, p. 176). Rogers et al (1998) report that health promotion units run projects and schemes in order to encourage schools to embrace health promotion activities and that these are often in partnership with local education authorities (Denman, 1999). There is some recent evidence to suggest that schools in Wales were increasingly relying on health promotion units and less on local education advisory services for support with health promotion work (Thomas and Keirle 2001). In Aggleton et al’s (2000) audit of schemes, it was found that there was variation in relation to how partnerships were funded, who had control over planning and what the level of commitment was. Funding was more likely to come from health promotion services, with schools providing teacher time rather than funds.

A second area where there has been collaboration is between the school health service and schools, typically led through the school nursing service. Based on work in Australia, Rowling and Jeffreys (2000) argue that the history of health service/school links has tended to cast schools in the ‘passive recipient’ role. They argue that in developing partnerships with the education sector, health workers need to reorient their expectations from seeing schools as organisations they want to change, to seeing schools as the instigators and owners of change for promoting health.

That many schools are engaged in some form of healthy schools scheme involving a health and education partnership is indicated by the findings of a recent audit carried out by Aggleton et al (2000). They found that around 2,500 schools were

participating in a healthy schools programme, which was supported by a health and education partnership.

Findings from the national audit of local programmes (Aggleton et al, 2000) are valuable in terms of elucidating the factors that facilitate effective partnership working between health and education sectors. There appear to be some general principles that underpin productive partnerships, irrespective of the sectors, agencies or professions involved and these relate to the power dynamics of relationships amongst those involved in the collaboration. For example, Aggleton et al (2000) found that effective partnership work could be characterised by the following factors:

- was inclusive in terms of relevant stakeholders, rather than exclusive;
- found a means to develop and engender a common vision;
- worked with schools in a non-prescriptive way;
- worked in ways that demonstrated respect for each other's differing priorities.

There were however a number of findings that were specific to the health-education partnership dynamic. For example, schools were more likely to be recruited to the healthy schools scheme if the education sector was directly involved as this was perceived by schools to add credibility to the scheme. Furthermore, in terms of a whole school approach to the scheme, many did not involve young people systematically. Other work by Moon et al (1999) found that schools had difficulty in developing partnerships with parents and young people. As far as partnership with the school nursing services were concerned, they were identified as having an important role to play but were felt to have largely been under-utilised by previous health promoting schemes. Furthermore, schools were unlikely to engage with a scheme if it was perceived to increase its workload. St. Leger (2000) also argues that if teachers perceive the scheme as 'imposed' from outside, and, furthermore, it is perceived as one that may necessitate professional development, then they are likely to be resistant to accepting the initiative. Bowker and Tudor Smith (2000) highlight the importance of key personnel in effective partnership work, namely, members of senior management and an enthusiastic co-ordinator.

2.5 Conclusion

Reviewing the policy context demonstrates that there is currently a central imperative concerning partnership working across sectors, particularly as it relates to improving health and educational outcomes. In terms of practice, it is also evident from the

literature that organisations and individuals may experience difficulties in engaging in productive partnerships, in spite of a centralist mandate. However, as the characteristics of effective partnership work become more clearly defined, then there are possibilities, at least in theory, for basing such arrangements on sound foundations. The next chapter explores the study design and method adopted to explore the development of the Cheshire health and education partnership.

Chapter 3

Study design and method

3.1 Introduction

This was a small-scale qualitative piece of work that looked in some depth at the development of the health and education partnership within the county of Cheshire. Qualitative research is often described as naturalistic in that it studies individuals in their natural settings (living or working), rather than experimental settings (Bryman, 2001). It also has a commitment to describing and explaining the world from the point of view of those being studied (Bryman, 1988). Such an approach was considered appropriate to studying the 'life worlds' of those involved in the development of the healthy schools partnership.

Given the boundaries defined by the research objectives in terms of time, geography and subject matter, a case study approach was adopted. This is a research strategy that focuses on the 'circumstances, dynamics and complexity' of a situation (Bowling, 2002, p. 403). The case study approach, typically, utilises several specific methods of data collection and these are described below. Employing different methods enables some degree of triangulation, as well as providing opportunities for exploring the complexity of situations in some detail. Bowling (2002) argues that it is an appropriate strategy for exploring complex social settings. Furthermore, given that the approach is conducted prospectively it is appropriate for exploring the development of a 'situation' over time. Inchley, Currie and Young (2000) have argued for the use of a case study approach when researching health promoting schools. It was for these reasons that a case study approach was adopted.

3.2 Data collection

As indicated above, case studies typically combine a diversity of approaches and data collection methods. In this study two qualitative data collection methods were utilised. Non-participant observation was used in two settings: the steering group and one of the locality groups. In addition, semi-structured interviews were conducted with 18 individuals.

Before talking in more detail about the data collection methods, the settings in which observation was carried out will be briefly described. At a relatively early stage the 'pre-steering group' decided that the structure for progressing the development of the

partnership and rolling out the programme would involve establishing two referent groups; a steering group responsible for strategic issues and an operational 'group' concerned with the delivery of the programme at a local level. In fact, given the size of the county, three locality groups were established: one in the west, one in the east and one in central Cheshire. Their membership, terms of reference and achievements are discussed more fully in Chapter 4 in relation to some of the findings.

3.2.1 Non-participant observation of steering group and locality group meetings

Non-participant observation is a method of data collection used by social scientists that does not simply rely on 'observation' but involves the 'direct gathering of information by the investigator using the senses, generally both sight and hearing' (Bowling, 2002, p. 358). In this way, the researcher watches, listens and records phenomena of interest. Thus, these settings provided an opportunity to 'observe' the development of the partnership in relation to both strategic and operational matters.

With reference to the purpose of this study, the main phenomena of interest from the steering group meetings related to:

- membership and attendance;
- chairing responsibilities;
- how work was progressed and by whom;
- how decisions were made and by whom;
- what were the main issues on the agenda;
- what were the main issues discussed;
- what were the issues over which there was tension;
- key achievements and milestones.

Data collection during meetings took the form of detailed note taking in relation to descriptions of events and processes. At times, this included verbatim recording of comments. The formal agendas and minutes from the meetings supplemented this information. In total, ten meetings of the steering group were attended between January 1st 2000 and May 31st 2001.

A similar process of data collection was carried out in respect of one of the locality group meetings. In total, six locality group meetings were attended between March 1st 2000 and 30th April 2001.

As with any data collection method, there are a number of advantages and disadvantages associated with non-participant observation. In terms of advantages, there is no reliance on the memory or knowledge of all parties. Furthermore, its naturalistic and prospective nature add to the ecological validity² of the findings (Bowling, 2002). Conversely, bias is possible in terms of observer bias, as well as the reactivity associated with the presence of the observer researcher at meetings. In terms of the latter, the longer the observation continues, the more likely reactivity is to diminish (Bowling, 2002). The main strategy for reducing bias was through researcher sensitivity to her own and others' behaviours.

3.2.2 Semi-structured interviews with 'key informants'

Semi-structured interviews have a 'loose' structure consisting of a number of open-ended questions that define the area to be explored, but which allow the interviewer or interviewee to diverge in order to follow up particular areas in more detail (Britten, 1995). Thus, although the interview topics and questions that led to exploring these areas had been defined initially in relation to the purpose, aims and objectives of the study, the semi-structured format allowed interviewees to express ideas that were important to them. It also meant that answers could be clarified and more complex issues probed than would be possible using a more structured approach.

The interviews took place during the three-month period June-August 2001, that is, after the process of observation of steering and locality group meetings. In this way, not only the literature, but also the issues that had been identified from the meetings, informed the development of the interview schedule. The schedule was piloted and a number of small amendments were made to increase clarity of some questions. The main value of piloting was that it became apparent that the schedule had to be sufficiently flexible to allow its operationalisation in respect of a diverse sample of interviewees. Questions were asked in relation to:

- roles, responsibilities and activities;

² Bowling explains ecological validity in terms of the 'realism of results outside the research setting' (Bowling, 2002, p.226). In other words, to what extent do the research findings, as presented, reflect what would have happened in the absence of a researcher?

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- perceptions of partnership working;
 - examples of partnership work at a strategic and operational level and in relation to planning, management and delivery;
 - perceptions of factors that support partnership work.

A copy of the interview schedule can be found in Appendix 1.

3.3 The sample

In order to study the development of the health and education partnership at both strategic and operational levels, participants were purposively selected according to their roles within the healthy schools programme. Thus, steps were taken to ensure that individuals were included in the sample if they had some involvement at the strategic and/or operational level of planning, management or delivery of the NHSS. This comprised individuals from the health and education sectors who were members of one or more of the following groups:

- the local steering group;
- one of the locality groups;
- working with or within schools.

Having defined the boundaries of the sampling frame, a purposive approach to identifying interviewees was adopted. This is a deliberately non-random approach to sampling that involves selecting individuals because they are viewed as 'key informants' (Bowling, 2002); that is, they were knowledgeable about their particular role and situation, as indicated above.

Insider knowledge through attendance at the steering group and locality group gave the researcher access to potential interviewees. Individuals were contacted in their professional capacity within the NHSS by telephone by the researcher. The nature and purposes of the research were explained to them and it was emphasised that interviews were confidential and all material generated by the interview would be anonymised in that no one would be identifiable in any report of the findings. Participation was on a voluntary basis. No individuals declined to participate. However, to some extent the sample was limited in size and role diversity by the timeframe and resources available.

Eighteen semi-structured interviews were carried out with individuals involved at a strategic and/or operational level with the NHSS in the County. A full list of interviewees is shown by job title in Appendix 2.

All interviews took place in the interviewees' places of work and were, with permission, tape recorded.

3.4 Analysis of material

All tape-recorded interviews were transcribed verbatim.

All material generated by both non-participant observation and interviews were subjected to thematic analysis and the development of categories of meaning. This was used in two ways:

- to draw up a description of the development and achievements of the partnership;
- to identify the processes underpinning the development of the partnership.

The findings from this analysis are presented in the following two chapters.

Chapter 4 Findings

The development of the Cheshire health and education partnership

4.1 Introduction

This chapter presents the findings in relation to the development of the partnership and progress towards objectives. The analysis is primarily based on material gathered from non-participant observation of the steering group and locality group meetings. This was supplemented, where appropriate, through access to relevant documentation and interview transcripts.

4.2 The development of the partnership and progress towards objectives

Figure 4.2.1 illustrates the development of the partnership and its progress towards objectives. This is not a chronological description of events and achievements, since many activities were progressed in parallel and were subject to interruption and alteration over time. Rather, the model identifies phases of work associated with the development of partnership arrangements over time. As such, it is, in part, a reflection of the outputs from the work of the partnership, for example in relation to the SALT website and the Process Handbook, as well as of the processes underpinning such outputs.

4.2.1 Phase 1 Setting things up: developing the partnership

The formal endorsement of the Cheshire Health and Education Partnership can be found in the Health Improvement Plan for South Cheshire Health Authority (2000) as well as in the Cheshire County Council Education Development Plan (1999-2002) both of which commit the organisations to collaboration through the Director of Public Health and the Director of Education at the County Local Education Authority (LEA). In reality, each of the Directors devolved their responsibilities to a health authority representative and the advisor for PSHCE respectively. Government funding for developing the healthy schools programme and local partnership was channelled from the then DfEE to the LEA. Thus, the line of responsibility and accountability for the funds and achievement of objectives resided with the LEA, which resulted in the

Figure 4.2.1 Phases in the development of the partnership

- Phase 1 Setting things up: developing the partnership**
- Utilising existing networks to set up the 'pre-steering group'
 - Recruitment to, and representation on, the steering group
 - Formation of the steering group
 - Consultation with young people
 - Clarifying the strategic and operational aspects of the partnership
- Phase 2 Developing the process for engaging schools: managing the programme**
- The Process Handbook
 - The Cheshire Standards
 - Setting targets
 - Forming the locality groups
- Phase 3 Developing the support network for schools: working in partnership in planning and delivery**
- The Resource Directory
 - Running the locality groups
 - Allocating the budget to localities
 - Mobilising school nurses
 - The SALT website
 - Devising and delivering training
 - Responding to resource demands
- Phase 4 Rolling out the programme: working in partnership in delivery**
- Recruiting schools
 - Meeting targets
 - Allocating money to schools
 - Monitoring progress
- Phase 5 Moving towards accreditation**
- Working together at strategic and operational levels

LEA, through the PSHCE advisor, taking the lead for developing the initiative locally. There were a number of implications to this funding arrangement, some of which are explored in chapter 5.

Two meetings³ took place between January and March 2000, prior to the establishment of the formal steering group. The advisor for PSHCE in Cheshire set up these meetings, which brought together a range of individuals from the health and education sectors. Use was made of well-established contacts that reflected existing networks of relationships. Comments from those involved in the setting up of the partnership suggested that consideration was given to two main issues. Firstly, individuals commented that it was important to get the 'right people' involved in the steering group. This was expressed in terms of breadth - representatives from health, education and other relevant statutory and voluntary agencies - as well as in terms of influence. In terms of the latter, consideration was given to ensuring that those with managerial responsibilities were involved. In reality, the membership of the steering group did not reflect those with responsibilities at senior management level, for example the Director of Public Health, but rather those at an intermediate managerial level. However, such individuals tended to manage staff and budgets and therefore had some 'power to make decisions'. They were also perceived as being able to liaise directly with those at senior management level. A further advantage of this arrangement, which became apparent over time, was that middle managers tended to have a role as representing their organisations on a variety of relevant working groups in the county. This led to opportunities for connecting the healthy schools programme with other initiatives and developments in the county.

A second concern was the extent to which, in a large county, support could be delivered effectively to schools. The decision was made, again by the 'fledgling group', to establish 'locality groups'. Thus, three locality groups were established as multi-professional and multi-agency *operational* groups. The value of operating at a locality level for delivery of the programme was expressed in terms of being consonant with the organisation of health services across the county and the networks of relationships that already existed. The locality groups were established and co-ordinated by health promotion services operating in each locality, and in

³ It should be noted that in the previous six months, there had already been a number of preparatory meetings designed to try and 'get the initiative off the ground' so to speak. However, these pre-dated the research but were a matter for discussion in some of the interviews.

practice, each group maintained some autonomy, which seemed to reflect the micro-dynamics of local situations.

These decisions gave rise to a two-tier arrangement, which sought to separate clearly strategic matters (planning and management of the programme) from operational (delivery of the programme to schools). Liaison between the two levels was maintained by the healthy schools co-ordinator, who was a member of the steering group and the locality groups. Health promotion managers who were members of the steering group also liaised across the two levels through their contact with staff who were members of the locality groups and responsible for delivery.

The membership of the steering group is shown in Appendix 3.

The operational tier of the partnership arrangements was led and co-ordinated by health promotion services, employed by the relevant NHS Trust. As indicated above, there was some variation in the way in which the locality groups were organised and the following description appertains to the west⁴ locality group in particular. (This was the locality group that was the focus of the non-participant observation). The west locality group brought together professionals and agencies with experience of working in schools, to varying degrees, which enabled consideration to be given to how, operationally, schools could be supported in the process of recruitment and development. What was new about this arrangement was that whilst there was a history of outside agencies and services working in schools, they had, hitherto, often lacked co-ordination. The locality forum was perceived as enabling a more 'joined up' approach to working at this level by raising awareness of the NHSS, as well as awareness of the range and diversity of agencies and activities, and the exploration of opportunities for working together.

One of the earliest activities initiated by the steering group was consultation with young people through a two day residential. The purpose of the residential was to find out from young people their views on what constituted a healthy school. In addition, the young people's views were also sought on the draft Cheshire Standards and evidencing of the standards. Nine schools were invited to send two young

⁴ The West locality group originally existed as two separate groups, one for Ellesmere Port (EAZ) and one for Chester. However, these two groups merged, partly in recognition of the fact that many agencies worked across both areas.

people from years 9/10. Schools were selected on the basis of the areas targeted for the initial work:

- an education action zone area;
- an area where there was a health promoting school scheme;
- a school who requested involvement.

There were three specific outputs from this weekend. Firstly, this was the first formal step in the engagement of young people within the partnership process. Processes were set in train that made it possible to build on this work through further consultation with the young people and involve them in a number of publicity events. In the case of the latter, there were examples where young people were directly involved in facilitating and participating in workshops. Secondly, the residential led to the development of a statement on the Cheshire Healthy School (see Appendix 4). Thirdly, the consultation exercise concerning the Cheshire Standards led to some amendment of sections 1, 2 and 3 of the document. Drugs and sex education were the two curriculum areas the young people thought important to include. Taken together, these can be construed as evidence of active engagement with young people with the purpose of developing a partnership with them.

4.2.2 Phase 2 Developing the process for engaging schools: managing the programme

At a relatively early stage, the process by which schools would be engaged was developed. This gave rise to the development of the 'Cheshire Healthy Schools Process Handbook', a guide for schools that outlined the framework as a series of stages through which schools are required to progress in order to become 'healthy schools'. The 'School Process Model' is illustrated in Appendix 5. The Handbook is described as a 'working document', in that it provides guidance to help schools work towards the priorities that they have set.

The Handbook was developed by the healthy schools co-ordinator, discussed at an early meeting of the steering group and amended for launch in November 2000. There were many references to the Handbook in the interviews and these will be explored in more detail in Chapter 5.

A second document, in this case produced by the PHSCE advisor, was the 'Cheshire Standards' document. It was one of the first documents produced and sent out to

members of the steering group for consultation in January 2000, and subsequently discussed at the March meeting of the steering group. The PHSCE advisor also established targets for recruitment, at a relatively early stage (May 2000). It was evident from the interviews that both these matters were a source of tension for some members of the partnership, matters which will be explored more fully in Chapter 5.

These examples are illustrative of the processes adopted by the steering group in relation to establishing the framework for the emerging healthy schools partnership. The lead agency (education) took responsibility for progressing key tasks outside of meetings, with work brought to the steering group for discussion in some cases. The context, timing and timescale within which much of the work took place were perceived by some to militate against extended discussion and consultation.

4.2.3 Phase 3 Developing the support network for schools: working in partnership in planning and delivery

A variety of activities were undertaken, at different points in time, concerned with the provision of support to schools. In part, this was a reflection of the stated view that schools, to a greater or lesser extent, would need support in order to be encouraged to engage with the process. In terms of the role of the steering group, discussion centred on the provision of financial and human resources. Firstly, the steering group made additional financial resources, in the form of £5000, available to each locality group for schools to access through a bidding process. Secondly, the amount of support that could be provided to schools from the health sector became a matter of discussion as more schools were recruited. The role of school nurses in the process of recruitment and support was identified as potentially problematic in certain parts of the county and as difficult to address, given the different ways in which they were employed across the county. The school nursing issue was a matter for discussion in the interviews and will be explored more fully in chapter 5.

The main vehicle for supporting schools was through the health promotion service in each locality, which, in conjunction with the county healthy schools co-ordinator, was responsible for engaging schools in the programme. The locality group itself (west), at least in the relatively early stages of the initiative, developed more as a forum for raising awareness of the NHSS and sharing knowledge of existing resources in the locality. In one locality this led to the development of a resource directory for schools in order to assist them in accessing support from outside agencies.

The recruitment of schools and the meeting of targets were monitored by the healthy schools co-ordinator who gave regular updates on progress to the steering group. It became evident that the setting of targets - for example, 100% of schools in the Education Action Zone - created pressures, in this case in the west locality where the EAZ was located. One implication of the relative success of recruitment was the increased demands that were made from schools for support with their work. This was particularly so in relation to health promotion services which provided the key personnel in terms of 'hands on' support. Given the model of funding for the development of NHSS at a county level, that is, that central government funding was channelled through the LEA, trying to accommodate the increased demands within the health promotion service in the west emerged as a matter for discussion in steering group meetings and with individual interviewees. One outcome of steering group meeting discussions was the proposal for the recruitment of 'locality development workers'. It was agreed that further staffing was required and, once the necessary funds had been found (via the LEA) three posts, one in each locality, were advertised in June 2001.

Other activities that were designed to support schools were training activities for teachers run by the LEA and the development of the SALT (Support and Access for Teachers) website.

4.2.4 Phase 4 Rolling out the programme: working in partnership in delivery

Partnership work at an operational level was evidenced in relation to the recruitment of schools. From descriptions of the process of recruitment given by those involved, as well as discussions at the steering group, a standardised process had been developed that was reported as ensuring consistency of operations across the county. In some cases, a dialogue with the school was established by setting up an initial meeting attended by the county healthy schools co-ordinator together with one of the local health promotion specialists. In many instances, this led to the direct involvement of health promotion specialists in initiating schools into the process. For example, a local health promotion specialist would arrange to go into schools and talk to them about the scheme and support them in identifying their priorities and discussing how they might work towards them. It was also evident that health promotion services were a vehicle for helping schools access help from outside agencies. In addition, there were examples of where individuals from health promotion gave help and advice on how to set up a school council, as well as direct

involvement in parents evenings in relation to explaining the NHSS and the work of the school within the initiative. There were also several examples of health promotion services, and, in some parts of the county school nursing services, being involved in providing training for, and resources to, teachers around specific issues, such as men's health and teenage pregnancy. Such work is indicative of the emerging partnership between health and education in the planning and delivery of the NHSS at an individual school level.

4.2.5 Phase 5 Moving towards accreditation

Accreditation is central to the healthy schools programme and can be viewed as an event that allows the partnership to demonstrate the depth and breadth of its achievements. Planning for the event was a prominent theme of steering group meetings, which monitored progress towards the event. However, work with the identified case study schools was carried out predominantly by those in health promotion and is another example of the way in which individual schools - teachers and pupils - worked with those from the health sector in terms of providing evidence of their achievements. The extensive display material that supported the accreditation day is a manifestation of such partnership work.

As part of the process of preparing for accreditation, various members of the steering group attended a number of training days. These were opportunities to work together on meeting the criteria for accreditation.

Chapter 5

The Cheshire Health and Education Partnership

The process of partnership working

5.1 Introduction

In this chapter the findings from the thematic analysis of interview transcripts are presented. This analysis adds context to the description of the development of the partnership presented in chapter 4 in terms of shedding light on the processes underpinning its development and the issues that emerged over time. For clarity and consistency, the main themes are organised under the same headings used in chapter 4 to describe the phases of the development of the partnership. In addition, given the focus of the study, a framework of 'sensitising concepts' was used, informed by the relevant literature, to examine and analyse the transcripts in relation to the:

- context within which partnership working took place;
- strategic and operational dimensions of partnership work;
- the planning, management and delivery of the local programme;
- evidence of partnership work in respect of relevant stakeholder groups.

Quotations from the interviewees are used to illustrate the themes and sub-themes identified from the transcripts. All quotations have been anonymised and all names used throughout are fictitious. Quotations are identified by a description of the individual's role and a reference number.

5.2 Phase 1 Setting things up: developing the partnership

In talking about the setting up and development of the partnership arrangements three themes were identified from the interviewees' narratives:

- contextual factors that enhanced or militated against partnership working;
- the strategic role of the steering group;
- the LEA as the lead agency.

These three themes are explored in more detail below.

5.2.1 Contextual factors

Firstly, without exception, all interviewees talked about some aspect of the context within which they carried out their healthy schools work. Much of the research on partnership working identifies the importance of context as a source of militating and enabling factors. Looking at the different dimensions of 'context' is therefore relevant to understanding the processes underpinning the development. It was possible to tease out three different sub-themes of 'context' from the interviewees' narratives:

- a history of working together;
- the 'Cheshire' factor;
- the reality of everyday working life.

For a number of individuals from both the health and education sectors there was a history of working together, in different ways, for a number of years. This was often expressed in terms of being a positive force for the development of the partnership in the sense that networks of relationships were established and that there were expectations that people from health and education would, should and could work together. This was particularly perceived to have been important in the early stages of setting up the partnership. For example, one member of the steering group from the health sector said:

'Well, the LEA had to sort of pull together people who they knew and who they thought would be able to work together to help address the very broad picture of national healthy schools and they were very broad based in that. I think they thought of the obvious to begin with but I think what was good was they thought broader than that.' (010/01).

A further way in which a history of working together was expressed was in terms of individuals' relationships with schools. Being known in a school, particularly by the head teacher, was perceived to be very important in engaging schools, particularly in terms of 'getting your foot in the door'. This is illustrated in the following quotation from someone from the education sector:

'So, I know the schools very well and I knew the heads really well and that did ... it does make a difference.' (001/01).

It was also evident that the experience of working together - or lack of it - was perceived as relevant in terms of the dynamics of working relationships within the partnership. For example, those with experience of working together perceived this to be valuable in terms of having the confidence to disagree with 'strong personalities'. This was in contrast to the views of some interviewees who were relatively new in post, or who did not have experience of working with those

members of the emergent partnership, and who found dealing with 'strong personalities' more problematic. For example,

'And there were dynamics within the group that we had to manage. It was a new partnership in as much as we had previous relationships and links with the other health promotion units and we also had previous separate links with education but some of the colleagues there were from other parts of the county that we hadn't actually worked with before. So that was difficult in as much as there were strong personalities there.' (Health promotion person; 011/01)

In terms of managing the dynamics of working relationships, it was evident that the county healthy schools co-ordinator was perceived to play a critical role, particularly given her ability to work in consensual ways, as illustrated in the following:

'Well, I support the person (the county healthy schools co-ordinator), the personality, she is always looking for consensus and common ground. That has worked very well. She is not looking for conflict at all and if she comes across conflict she has got to resolve it, which I think is a lovely characteristic And I think that has been vital for the success.' (Health promotion manager; 010/01)

Generally however, interviewees expressed the view that it was 'down to the individual' to make things work. The following quotation illustrates this point:

'I think how it works is very much down to the individual. Valerie has never been terribly happy about ringing up Elaine but there's an element of, she's not known her as long as some of us have so that would cause reticence and I know some people in Central don't have issues around that as well.' (Health promotion person; 003/01)

A second sub-theme to emerge from the interview transcripts was that of the particularity of the county of Cheshire. The size of the county and the consequent number of schools were perceived to present problems in terms of achieving targets. This was perceived to be compounded by the socio-economic diversity within the county and the differing needs this generated. Furthermore, it was evident at a strategic and operational level that the different ways in which health services were organised and structured across the county created some difficulties. This was predominantly a theme in relation to the school nursing service and is explored more fully below.

The time at which the interviews took place coincided with a number of national policy initiatives within the health and education sectors. Individuals in both health and education identified the amount of change in 'the system' as militating against effective partnership working. For example, the following were specifically identified as generating changes that had to be accommodated: the re-organisation of the health service including the creation of primary care groups/trusts and the dissolution of existing organisations; the introduction of the Connexions service; the number of new initiatives and the attendant monitoring of their implementation; the proliferation of working groups and committees concerned with children and young people that made it difficult to 'join things up'. However, it was also evident that there was a perception that change of this magnitude presented opportunities for 'joining things up' at a strategic level and this is explored in more detail below.

Working in a turbulent environment, as described above, was an aspect of the reality of everyday life for professionals, which was perceived to make partnership work difficult at times. For example, staff turnover, illness, secondments and people 'acting up' for short periods of time to fill gaps, were cited as frustrations. The reality of everyday professional life was also talked about in terms of how busy 'everybody' was, being overwhelmed by the volume of work and the short deadlines. These matters were perceived to be not only disruptive to the emerging networks of partnership relationships but also to make it more difficult to engage schools and other partners, such as the new PCTs, who would have their own agendas and priorities. For those working in the health sector, the establishment of the PCTs was perceived as a 'threat' to involvement in healthy schools work, as illustrated in the following:

'I think with the context of the Primary Care Trust coming on board now, that it has put another pressure on us as to what we will be doing next year. How much involvement can we say we will have (in NHSS)? You just don't know in a context of change That is bound to affect us.' (Health promotion person; 002/01)

Overall, the reality of everyday life for professionals working in the health and education sector could be understood in terms of 'fatalism'; that is to say, people were resigned to the fact that further change was likely to be just around the corner, even in respect of the healthy schools initiative itself. The following quotation is illustrative of this view:

'Sorry to sound cynical again, but you start something new and initially you get great input and then enthusiasm just wanes because the next thing comes along. I mean over there behind my desk is last week's reading and it's about nine inches. You know, every week people are getting their new nine inches. Yes, so the next thing comes along.'
(Health promotion manager; 004/01).

5.2.2 The strategic role of the steering group

It was evident from the transcripts that interviewees identified a clear 'strategic' role for the steering group, with responsibility for planning and, specifically, accreditation. There was general agreement that the delivery aspects of the NHSS had to be organised in 'localities'. In talking about the strategic role of the steering group two complementary sub-themes were identified that reflected different dimensions of its strategic role. Firstly, the matter of 'raising and maintaining strategic awareness' was identified and there were two ways in which this was expressed. It was evident that steering group meetings were perceived as providing valuable 'opportunities' for exchanging information. In part, this was seen as 'bringing different perspectives' - LEA, health promotion, school, and so on - to inform discussion. In part, this was also seen as providing a forum for sharing information about relevant developments across the county. This enabled discussion of how healthy schools work might be 'knitted into' other, related strategic developments, as well as allowing individuals to go back to their own organisations and agencies and further disseminate information. Secondly, given that some members of the steering group were also members of other relevant working groups, this enabled them to raise awareness of the healthy schools programme at a strategic level. In this way the steering group acted as a vehicle for the dissemination of information across quite a complex network of strategic relationships that allowed the healthy schools programme to be 'kept on the strategic agenda' across the county.

A second and related sub-theme was the perceived role of the steering group and its members in terms of 'joining things up' across the county. This was articulated in terms of a responsibility to not only disseminate information but to seek actively to develop a more coherent and strategic approach to work with children and young people in schools across the health and education sectors. (This was also a prominent aspect of steering group meeting discussions.) The 'healthy schools programme' was seen as the vehicle for doing this. The means through which this was possible was via individuals' membership of other related planning groups in the

county at which the profile of the healthy schools programme could be raised, for example in relation to work surrounding drug education initiatives, teenage pregnancy, community safety and so on. As pointed out above, the time at which the study took place coincided with a number of policy initiatives in relation to children and young people, as well as the emergence of new structures and planning groups. The opportunity to 'join things up' was therefore also seen in terms of seeking to ensure that the healthy schools programme was embedded into the work of these emergent structures and groups where possible. It was expressed that this was seen as the prime means for healthy schools work to be sustainable in the longer term as well as being a means to ensure that change might be endured. This is illustrated in the following quotation:

'I suppose at a strategic level I think it's about joining up agendas and making sure we're all attempting to operate from as best a possible position to help schools. So making sure it's with PCTs, that it's in EDPs (education development plans), school DPs (development plans) and all those sorts of things..... It's about trying to reduce the number of groups that are currently there talking about young people and health issues.' (Education, steering group member; 007/01)

A further sub-theme was identified in relation to the critical role of the steering group in developing the process. The steering group was viewed as the vehicle by which the process was 'quality assured'; that is to say, provided consistency of operations across the county, was sensitive to schools' needs, and provided a framework within which healthy schools work could develop. This in turn was seen as providing 'legitimacy' to the initiative, perceived as being important at an operational level. For example, one member of the steering group (from the health sector) said:

'Well, the strategic group it is maintaining the overview It developed the process. The strategic group said, 'well, how are we going to take this forward in Cheshire?' And a lot of the direction on how it was going to be taken forward came from the strategic group they also saw the vision of the localities And the young persons' involvement came from there and the links to the bigger picture. And it also gave validation to taking it back into the areas where we were working and actually making it happen.' (010/01)

There was also some evidence to suggest that interviewees perceived the steering group to have given time to developing a 'vision':

'Yes, we are a pretty healthy alliance (the steering group). I mean that is my view. It does try to get a shared vision.....'

so yes, we do sort of share the vision’ (Health, member of the steering group; 008/01).

5.2.3 The LEA as the lead agency

Those interviewees who were involved, talked about the early days of setting up the partnership in terms of difficulties and tensions. From these narratives the theme of ‘the LEA as the lead agency’ was identified. The critical issue was that previous work in the county around healthy schools had been led by health promotion, particularly in the east of the county where there had been involvement with the health promoting schools scheme, with the LEA generally providing only limited support. Associated with this issue was the matter of funding and control of funding. The NHSS initiative nationally was funded from the DFEE through the LEA, which, in turn, had the associated budgetary and delivery responsibilities. Furthermore the lead health agency was the health authority rather than health promotion. Locally, this divergence from established practice, in which health promotion was perceived by some to have been ‘marginalised’, was identified as the origin of the difficulties and tensions for those who were involved in the early developmental stages which preceded the setting up of the formal steering and locality groups. This is reflected in the following quotation from a member of the LEA who was on the steering group:

‘It feels to me like a healthy group now (the steering group) but there was some difficulty initially because it felt like there was quite a lot of resentment from health promotion staff ... and not just in Cheshire ... and it was quite difficult to deal with.’ (007/01)

To some extent, the situation was compounded because health promotion services were still expected to carry the work on the ground, since education had no ‘doers’.

There were other examples of the implications of the LEA being the lead agency that were the subject of discussion which are explored more fully below.

5.3 Phase 2 Developing the process for engaging schools: managing the programme

Two themes in relation to developing the process for engaging schools were identified:

- the value of the Process Handbook;
- working empathetically with schools.

The value of the Process Handbook - in strategic and operational terms - was a common theme of interviewees' narratives. People talked about the value of the Handbook in two ways. Firstly, it was valuable because, as indicated above, it provided a clear and consistent framework for schools, which took them through the process logically. Thus, people talked about the Handbook as providing 'standardisation', as being 'prescriptive' and providing a 'common language'. This point is reflected in the following quotation:

'I felt I had to hold the reins across the whole county and know what was going on. That was the reason I felt we needed a healthy schools process handbook and that is why the first term I worked on the handbook in partnership with the health professionals. We all wanted a consistent approach across the county so we all knew what we were doing and what we were saying when we went into schools it's given us a common language.' (Education, member of the steering group and locality groups; 001/01).

Secondly, people perceived the Handbook as enabling schools to set their own priorities, a matter that was seen to be important in developing 'ownership'. For example, one teacher (the school co-ordinator) said:

'I quite like the structure. I don't feel we've been hindered in any way because the most logical thing is the audit, then looking for gaps. It's actually helped us ... it's made us aware of certain issues that perhaps may be, last year, or the year before, we thought we were covering but we were not covering them as well as we could. So it's raised our awareness of things that are going on by trying to put things right. You know, we thought, that's OK but it wasn't.' (014/01).

The second theme to be identified from the interviewees' narratives was concerned with the perceived importance of working empathetically in support of schools. When interviewees were asked to talk about the way in which schools were approached

and initiated onto the process, people expressed the view that schools needed to be actively encouraged and supported. People talked of the pressures that schools were under, for example in relation to impending OFSTED inspections. For example one person from health promotion said:

'We're hitting a really busy time now with SATS and exams and such like to sort of sell this scheme to them I believe there is no use forcing a school, you are going to lose a school. I would rather have them enthusiastic than feeling that I am there with a big stick saying, 'I must come in and you must sign up.' I don't feel that that is the way forward for them.' (006/01).

Furthermore, the view was articulated that in introducing the idea of NHSS to schools it was important that it should not be seen as 'just another initiative', nor that schools would perceive that they would be 'left to get on with it on their own'. Overall, the view was expressed that the NHSS was a vehicle for helping schools; either in terms of making explicit what they were already doing or in terms of helping them address matters that they had hitherto been unable to address on their own. Help to schools was also articulated in terms of developing 'a relationship'. For example, one person working in health promotion said:

'I think it's about trust and I think one of the selling points that we have to make about the NHSS is that there's not an awful lot of work needs to go into this. I think if you level with the school and you level with the teachers who are going to be responsible for taking it forward and say, 'yes, it's a bit of fiddling and faffing at first but you know that it'll be worth it in the end' that establishes some sort of trust.' (003/01).

That appropriate support was given to schools is reflected in the following quotation:

'I mention her (our health promotion link person) because she's been superb. I think she's quite keen that we get it moving along with her as well. Obviously it's personalities involved as well, isn't it? If you get a team that will work well together and gel then they will work to take things forward and Debbie's been very good from that point of view. As I say, it was Debbie who came to launch it to the staff as well at a staff meeting.' (Primary school head teacher; 009/01).

The role of the steering group in developing the process has already been discussed. However, a further critical person in the development of the Cheshire process was perceived to be the county healthy schools co-ordinator. Much of the work in terms

of co-ordinating the initiative across the whole of the county was perceived to be largely down to her; writing the handbook; organising the website; consulting with young people; supporting people at an operational level; liaising between the steering group and the locality groups; monitoring recruitment, and so on. For example, one member of the steering group said:

'The post was needed so that someone could hold it all together and someone who could build a lot of relationships.' (004/01).

This illustrates the key role of building relationships as a foundation to the emergent partnership. The ability and predisposition to work empathetically across a complex network of relationships - particularly at the interface between steering group and operational group, and operational group and school - was emphasised by interviewees.

5.4 Phase 3 Developing the support network for schools: working in partnership in planning and delivery

A number of issues were talked about when interviewees were asked about the ways in which schools were actively supported. Taken together, the themes can be understood in terms of a desire to enhance the quality of support to schools across the county. This suggests that at a strategic and operational level, improving the quality of provision was central to the aims of those in the partnership. Three themes were identified:

- the locality group as a vehicle for 'joining things up' locally;
- mobilising school nurses at a strategic and operational level;
- the role of outside agencies.

5.4.1 The locality group as a vehicle for joining things up locally

Although there were some differences in terms of how the locality groups operated in the three areas, people's view of the role of the locality groups could be understood in terms of a concern with trying to 'join things up' at a local level. Two dimensions to this theme could be identified. Firstly, 'joining things up' was seen in terms of seeking to increase co-ordination and coherence of operations in respect of support provided to schools from outside agencies. This is illustrated in the following quotation:

'It was about getting people involved and getting people on board and trying to make links inviting other people who had an involvement with schools to try and see the significance of national healthy schools and just trying to get them to make the connection between what they were doing with the standards that Cheshire had set out so that we would be providing a co-ordinated and cohesive provision to the schools in terms of information and resources.' (Health promotion person and chair of locality group; 002/01).

The locality groups were also described as providing a forum for raising awareness of the NHSS and, as reflected in the above quotation, stimulating members of outside agencies to consider how they might 'fit' their work under the NHSS 'umbrella'. This was seen as a vehicle for avoiding 'one off' sessions from outside agencies. The role of outside agencies in providing support is explored more fully as a separate theme below.

There was a second way in which 'joining things up' was expressed by those from the health sector and that was in terms of seeking to ensure that the healthy schools work was placed on the emerging agenda of the PCGs/PCTs and linked into other locally relevant initiatives. For example, one health promotion person saw this as an opportunity:

'I think they are actually sick of NHSS at the PCG because we are constantly pointing out the links with other initiatives in terms of national service frameworks in terms of the Heartstart scheme the community safety partnership which is now thoroughly linked into the NHSS The health improvement team gets a report and update every month It's been linked with the healthy living centre should that happen. Where there's the remotest possibility we link it in.' (003/01).

From these two descriptions it can be seen that the NHSS was viewed as a vehicle for developing better co-ordination at a local level of service delivery to schools. This was also reflected in the way that school nurses were operating in some parts of the county:

'I think the thing we should be aware of here is that everything we do in school should be put under the umbrella of 'healthy schools' and I think that because it's been talked about so much in the last twelve months and every conference that I've gone to the term 'healthy schools' has been mentioned and I think people are seeing their role and how we fit into the umbrella and I think that's probably a culture change.' (School nurse manager; 016/01).

5.4.2 Mobilising school nurses

The mobilisation of school nurses in the NHSS was identified as a theme from interviewees' narratives. The overwhelming view was that school nurses were central to the process of recruiting and supporting schools. However, the management of the school nursing service, in particular, the employing organisation, was identified as an important factor in enabling or constraining school nurses' involvement as partners in the local programme, at both a strategic and an operational level. There was not one countywide school nursing service; rather, the management of school nurses was via four different NHS trusts. The number of school nurse managers this generated was perceived to pose a problem. Whilst representation on the steering group was viewed as important by its members, who to invite to 'represent' the service in this situation was seen as problematic. This had, in fact, led to their absence from the formal steering group, as reflected in the following quotation:

'The problem with school nurses is that they come, in Cheshire, from four different trusts. Who do you have to come along to represent them when you have got four different organisations? They seem to be the ones that are missing from the partnership ... they are the ones I worry about more than anything.' (Health authority representative; 008/01).

A second way in which the 'employing organisation' was perceived to be relevant to whether or not school nurses could be fully mobilised related to whether or not the school nursing service was part of an *acute* or a *community* NHS trust. Being employed by an *acute* NHS trust was perceived to result in school nurses having a limited 'medical' role in schools, largely centred on screening and immunisations. For example, one health promotion manager said:

'I cannot criticise individual school nurses but their management is from the hospital and they work to a medical agenda all the time it seems odd, it's called national healthy schools and the people who traditionally have always worked in schools from a health point of view are school nurses and they're not linked in.' (010/01).

This quotation can be contrasted with the following, from a school nurse manager, who explained how, from a management perspective, school nurses were enabled to contribute to the NHSS:

'It's certainly in the new job descriptions – it's very, very black and white – that they will be acting on behalf of the school. They will be expected to attend meetings for the healthy schools and to promote it.' (016/01)

These quotations illustrate the way in which the employing arrangements of school nurses could lead to their marginalisation or active involvement as a partner in different parts of the county.

The 'employing organisation' was also viewed as a factor in enabling the school nursing service to work in a 'joined up way' with health promotion services. Across the county health promotion services were employed by three *community* NHS trusts. In the east, the school nursing service was also employed by the same community trust. This was perceived as enabling partnership work between the two services, whereas in parts of the county where there were different employers for each service, such as in the west, partnership working was perceived to be difficult. Such differences across the county were commented on by individuals in terms of support that could be expected. The following two quotations illustrate these divergent views:

'I think a lot of it came from my predecessor. She'd actually done a lot of hard work with health promotion so I think the relationship was there and we've continued ... and we've certainly continued to support each other with ventures we've done under the healthy schools scheme. We do work together and we speak on a regular basis.' (School nurse manager; 016/01).

'It's almost like the dead hand of bureaucracy really there's another layer, another Trust, you can't assume anything. You can't promise a provision, you can't promise an input.' (Health promotion person, chair of locality group; 003/01)

A further theme was the specific role of school nurses within schools. This is explored more fully in section 5.4.3 below.

5.4.3 The role of outside agencies

The role of outside agencies in providing support to schools as part of the NHSS was identified as a theme from the interviewees' transcripts. In this context, outside

agencies refers to any statutory or voluntary agency that is outwith the education sector. A number of different sub-themes could be identified, each of which are explored below in more detail.

Firstly, outside agencies were seen as central to supporting schools in a variety of ways. The perception was that schools would *need* outside support and, as part of the NHSS, should actively seek it. A number of examples of the ways in which outside agencies were working to support schools could be identified from the narratives:

- health promotion services recruiting schools and supporting them with the process, such as completing the audit, talking to parents at parents evenings, talking to staff;
- health promotion services 'signposting' schools to other agencies;
- school nurses training teachers to be better able to teach some aspects of the PSHCE curriculum;
- school nurses, health promotion services and other agencies providing resources, including human resources, to support teaching;
- school nurses and health promotion services providing advice and practical support in the development of new initiatives, for example, setting up a school council and running a school-based drop-in service;
- school nurses, health promotion services and other agencies talking to children and young people about specific issues, such as sexual health.

That schools welcomed this support is reflected in the following quotation:

'They help us Give us information and help us with our training. I don't want them to come in and take over They come in and we work as a team. I can go to Margo (in health promotion) and say, you know, I feel we need to do more on sexual health, who do you advise I go and speak to? So for instance we've got the school nurse manager coming in to do some training with our Year 10 and 11 PSHE tutors around men's health she's coming to train the teachers to help us deliver the programme, not to do it for us, help train, so we can tap into help.' (Secondary school teacher, healthy schools co-ordinator; 014/01).

There was a general perception among the interviewees that schools were not always good at accessing help when needed. In fact, one of the benefits of the

NHSS was perceived to be that they would now know who to go to for assistance, as reflected in the following quotation:

'If you get stalled, she can point you in the right direction. Some things I think 'who do I go to for that?' you know, but she (person from health promotion) seems to know. They've got the knowledge there so it would be easy for us to find the agencies in the future because we've got the one person and they can tell us.' (Primary school governor and school co-ordinator; 012/01).

However, it was evident from the narratives that there was some tension and confusion over the exact role of outside agencies in schools. In part, confusion appeared to be the consequence of a perceived change in the role of, for example, school nurses, who, in some parts of the county, had previously delivered teaching sessions to children and young people. Members from the health sector - health promotion and school nursing services - articulated the view that 'they had a lot to offer' and that schools wanted specialist input around, for example, sexual health and drugs. However, the main way in which involvement of outside agencies was described was in terms of a 'resource' rather than as a teacher. This is reflected in the following quotation from someone working in health promotion:

'I think they (schools) value the support they get from school nurses or other agencies and it is actually written in the standard, yes, use other agencies get them involved, plan the lessons with the teacher, don't just arrive on the day, so you know what you're there for You're not there to deliver a lesson, it should be the teacher that's doing that but supported by an outside agency.' (011/01)

It was evident that members from the health sector perceived the LEA ('at quite a high level') to be against the use of outside agencies in the *classroom*. The view from someone from the LEA was expressed thus:

'Any work within the school classroom should be planned, delivered and evaluated with the teacher Certainly planned and evaluated these are things that teachers can do. They may be nervous about it (sexually transmitted diseases) but if somebody works with them it's possible.' (007/01)

It was evident from the narratives that this was a current issue that was causing some tension among the partnership. However divergent the views expressed were

appertaining to the role of outside agencies, there was convergence in that all interviewees articulated the view that the main purpose was to improve the quality of support to schools. In fact, the descriptions given of the ways in which outside agencies supported the work of schools were in terms of a resource rather than a teacher and could be described as an example of good practice in relation to partnership working.

5.5 Phase 4 Rolling out the programme: working in partnership in delivery

Rolling out the programme was talked about in relation to three themes:

- making a difference to schools;
- the human resource issue - the demand for 'doers';
- relationships between the operational (locality) and strategic (steering) groups.

5.5.1 Making a difference to schools

Interviewees expressed the view that many schools would need 'persuading' to sign up to the scheme. However, frequently this view was expressed in tandem with comments that revealed some empathy for schools, as discussed above. When talking about the impact of NHSS on schools the theme of 'making a difference to schools' could be identified. This was explained by head teachers and school co-ordinators in terms of 'focussing our minds' and 'raising our awareness of things we thought were OK but weren't'. It was also the view that the NHSS had already started to make a material difference to some schools, enabling them to bring things to fruition. For example, one head teacher said:

'Well, it's started to make a difference already, because apart from being in our school development plan – being a healthy school – because of the way we've gone about it, staff have said, we've not got any cool drinking water machines, which we've got now. The children said, we haven't got anywhere to sit at lunchtime if we want to go outside so we bought some wooden benching and seating and made a little garden area So in terms of improving the environment it's started already. The advice clinic's up and ready to go ... so yes, things are happening already it's really focussed our minds.' (Secondary school head teacher; 015/01).

In this sense then, the NHSS could be understood in terms of a catalyst that enabled schools to accomplish things they had wanted to do for some time. In part, this was

facilitated by access to small amounts of money, which were seen as providing some degree of 'incentive' to schools. A further way in which the NHSS could be seen as acting as a catalyst was in relation to the process of consultation with children and young people. This is reflected in the following quotation from a school co-ordinator:

'More drinking water, yes, that's one of our targets and that actually came from talking to the young people, actually letting them have a voice in the school.' (Secondary school teacher and school co-ordinator; 014/01).

5.5.2 The human resource issue - the need for 'doers'

This theme was identified in order to describe the interviewees' views on the implications of striving to meet the recruitment targets. Concern was expressed in terms of how the parallel activities of school recruitment and support could continue to be carried on the ground by health promotion - the 'doers' as one member of the steering group described them. It was evident that the setting of targets was perceived to have increased the pressure on those working directly with schools, and this was particularly the case in the locality in which the EAZ was situated. However, pressures were felt elsewhere because of changes in staff. This was summed up by one individual in terms of the tension between 'quality and quantity', a tension that was particularly acute in one part of the county where there was no additional funding to health promotion services to support the healthy schools work.

The matter of providing additional human resources to support the development of the initiative on the ground was also a feature of discussions at steering group meetings. The way in which the problem was addressed was by the LEA identifying sufficient monies to support the appointment of three 'locality workers'. This was one of the first major decisions that the steering group had made and it generated extended discussion at both steering group meetings and in the interviews. In part, this was because of the timing of the research, which coincided with the appointment of the new people. Much of the discussion centred on the issue of 'control'; control over the budget, control over the arrangements under which the locality workers would work, and so on. The process of recruitment - short-listing and interviewing - was carried out with members of health and education working together. One outcome from the discussion was that there was agreement that the locality workers would be based in the locality alongside health promotion. This was perceived to be a necessary step forward by those working in health, as reflected in the following quotation from a health promotion manager:

'To be fair, Sylvia has acknowledged that (the need for 'doers') by putting more money together to employ three individuals who can work in west, east and central. She did move on that. But they should work alongside health otherwise there will be problems.' (010/01)

5.5.3 Relationships between the steering group and operational groups

The two tiered structure of the partnership and the relationships between the two tiers were a matter of some discussion in the interviews. The main channel of communication between the two levels was via certain people who occupied roles at both a strategic and an operational level; health promotion managers and the county healthy schools co-ordinator. These people acted as conduits for the two way traffic between the two tiers.

For those working at an operational level there was a perception that the steering group was somewhat 'detached' from the everyday reality of recruiting and supporting schools, particularly in terms of trying to meet targets and deadlines. For example, one health promotion person said:

'I sometimes wonder if they (the steering group) have a true viewpoint of what goes on on the ground in that there have sometimes been difficulties in us generally across county on the ground wanting to do things and the steering group perhaps not completely understanding why or then later blocking.' (002/01).

One consequence of this was that there was some frustration felt among those working operationally and there were two dimensions to this. Firstly, feeding information back from schools about, for example, the wording of the standards and the requests for funds was perceived to be difficult in terms of reviewing decisions. For example, one member of the health promotion service (and member of the steering group) said:

'The steering group should be able to say, 'that's not working – let's change it' ... based on experience. There is a bit of reluctance. That's why I say within the partnership there is a bit of a reluctance to change things that people feel precious about.' (004/01).

Secondly, there was a feeling that decisions were not 'negotiated', for example with regard to the targets for recruitment:

'So at no stage until the form went in did I know Ellesmere Port was going to be the target. So that wasn't negotiated, that had been done to us.' (Health promotion, member of locality group; 003/01).

There was also a perception that the origin of some of the tension was because people in health and education tended to view the initiative in different ways; education was perceived to be outcome focussed and health process oriented. This was reflected in the view that reaching targets was important, as reflected in the following quotation from a member of the steering group from education:

'I suppose because the responsibility is on education, so it felt like my responsibility to make sure things were done, even though it's the steering group's really, but if you're in health, they're not responsible for schools, so if they don't achieve targets that doesn't matter to them.' (007/01).

The way in which decisions were made was, as indicated above, a source of frustration to those who were required to work with the decisions made. However, it was evident from the narratives that there was a notion of the requirement for the NHSS initiative to be driven by leadership, and that this was important given the timescales within which achievements were to be accomplished. The matter of the chair of the steering group was discussed at steering group meetings and opened up for nominations. This led to a new chair from the health sector being selected, which lasted for one meeting, before reverting back to a chair from the LEA. One interviewee thought that a rotating chair would be useful. However, over time there appeared to be some growing acceptance that the LEA lead, and the model of leadership adopted, would be effective in progressing the initiative, as reflected in the following quotation from a member of the steering group (health):

'In some ways they (the steering group) were just confirming what Wendy wanted. You know, Wendy would come up with a proposal and the group said, yes, that's a good idea, but because it was a good idea. I think the group would have said, no Wendy we don't want to do it that way, let's do it this way. I think Wendy has got a huge amount of knowledge about what works and what doesn't work.' (003/01).

A number of comments can be made in relation to this representation of leadership and decision making. Firstly, it was evident from steering group meetings that a

considerable amount of work went on outside of meetings with regard to discussion, production of documentation, some consultation and related decision making. In large part, it was evident that this was necessitated by the timescale within which work had to be completed and the schedule of steering group meetings (about one every two months). Together, they were a source of some pressure for decisions to be made outside of the steering group. On these occasions, this meant that the steering group was a forum for the reporting of decisions about which there was further discussion or, occasionally, amendment, as indicated above. In general, there was acceptance that this was necessary if progress was to be made and in this the steering group can be understood in terms of acting as a vehicle for monitoring progress rather than as an obstacle to progress. In these circumstances, the two central characters involved in decision making were the chair of the steering group and the healthy schools co-ordinator. Given the considerable outreach work of the co-ordinator in terms of her liaison with colleagues in health promotion, there were opportunities for consultation with other members of the steering group between meetings, as well as those working at a locality level. In this way, the co-ordinator was able to act as a vehicle for horizontal (across the steering group membership) and vertical (between the steering group and locality groups) communication, allowing decision making to be informed by a wider constituency than might otherwise appear. The role of the co-ordinator in acting as a vehicle for the 'two way traffic' of communication was perceived as crucial in keeping a widely distributed constituency informed about developments, as discussed above.

5.6 Moving towards accreditation

Two themes were identified from the comments made in respect of discussing moving towards accreditation:

- a sense of achievement;
- maturation of the partnership.

All interviewees talked about their 'achievements': reaching targets; developing a process that enabled consistency across the county; engagement with young people; a sense that schools had been helped. The work that was being carried out with schools and young people for the accreditation day was identified as a reflection of the achievements of the local programme across the county.

It was also evident from interviewees' narratives that they perceived that, over time, the partnership had 'matured' and that this was as a consequence of the experience

of working together. In many ways, this view was also bound up with their sense of achievement borne of their collective commitment to make things work. This is reflected in the following quotation from someone in health promotion:

'A year ago we just wouldn't have been like that as a partnership But on the day we were all there saying the same thing had the same vision it was really good.'
(004/01)

Chapter 6

Discussion

What is the evidence that the Cheshire healthy schools programme is a ‘partnership’ based in health and education?

6.1 Introduction

Chapters 4 and 5 have described, in some detail, the development of the Cheshire partnership over time and the processes that underpinned its development. This chapter considers this evidence in order to examine the question of the extent to which the healthy schools programme in Cheshire is a partnership based in health and education.

6.2 The model of partnership arrangements

The description of the development of the partnership depicted in chapters 4 and 5 can be used as a basis for delineating a model for the emergent partnership arrangements. Using the typology outlined by the Audit Commission (1998) and discussed in Chapter 2, the Cheshire health and education partnership has many of the features of the simplest and least formal model: a steering group without *dedicated* staff and resources. In this arrangement, the work of the partnership is progressed by the partner organisations as part of their mainstream work. In part, this was enabled by specific funds from the then DfEE to the LEA to develop the initiative. Part of the funds allowed a dedicated ‘partnership’ post to be created. Thus, the county healthy schools co-ordinator was appointed (employed by the LEA), who was responsible for developing the process, recruiting and supporting schools, and liaising with locality groups. However, the requirement to embrace the additional support to schools through existing programmes of work fell largely to health promotion services, which received no additional funds. This is one of the disadvantages of this type of arrangement, where dedicated resources are either limited and/or distributed to only one of the partnership organisations. That health promotion services would and could incorporate the work was made possible by the willingness and capability of health promotion managers to mobilise staff. Involving them on the steering group was therefore critical to harnessing the operational capacity required for successful recruitment. Demonstrating interdependence has been shown to be a factor in the success of partnership arrangements. Whilst the NHSS was a mandated partnership, there was a very real set of interdependencies

between health and education at a local level; put simply, education needed the health sector.

A further stated advantage of this model is that it enables programmes to be better co-ordinated across organisational boundaries, which in turn can lead to better quality of service provision. One outcome from the work of the steering group was the development of the 'process', as reflected in the Handbook. The standards, as part of that process, were also a contributing factor to 'benchmarking' the quality and consistency of the local programme as it unfolded. Taken together, these were instruments that were perceived to lead to a process that was rolled out consistently across a large and diverse county and had a benchmarked quality. In this way the local programme addressed previous concerns about the quality of, and variation in, local programmes.

A second way in which coherence at a strategic level across the health and education sectors was perceived to be enhanced by the partnership arrangements was through the opportunities taken by members of the steering group to link the healthy schools work with other key initiatives in the county. Thus, the idea of the 'NHSS umbrella' was used to try to reduce potential fragmentation across the health and education sectors as new initiatives were introduced. Work in relation to sexual health, teenage pregnancy and drug education for example was discussed in terms of being addressed through the NHSS local programme. These points go some way towards addressing the previous concerns identified in the literature about greater co-ordination of services across sectors.

There was also evidence to suggest that at an operational level the locality groups were a vehicle for co-ordinating delivery of services to schools and avoiding 'one offs' and repetition. There were examples of outside agencies working with schools in support of their identified priorities. This way of working with schools goes some way to addressing the criticisms of previous schemes, including the ENHPS scheme.

The Cheshire model had an additional layer of complexity in terms of the operation of three locality groups. To some extent, this appeared to make the work of health promotion services more manageable in that they were able to work in a patch with a defined number of schools with which they had some experience of working. Having an operational tier created the need for channels of communication to be established between the strategic and operational groups. In part, this was mediated

through health promotion managers and the healthy schools co-ordinator who all had formal and informal links with the steering group and locality group(s). The effectiveness of this arrangement was, in large part, determined by the skills and pre-dispositions of the 'link' people to raise issues of concern. To some degree, this was mediated by a history of working together for some members, which gave them the confidence to raise issues. It was also evident that a key role was played by the healthy schools co-ordinator, in terms of the value of a dedicated post to co-ordinate the programme as well as the skills and qualities of the incumbent. Nonetheless, the pressures on individuals to raise matters of concern under the arrangement is evident and can lead to a sense of disempowerment at an operational level if decision making is not carried out with full consultation. Perhaps inevitably, the effectiveness of communication will reflect the quality of the informal and formal channels of communication that develop over time among the participants of the network.

Given the more recent addition of dedicated staff to the programme in the form of the three locality development workers, employed by the LEA, the partnership arrangements are changing again. Furthermore, there was some indication that health promotion services in some parts of the county might become less rather than more involved with healthy schools work. With greater involvement of dedicated staff and less involvement from mainstream services, the greater degree of co-ordination across the health and education sectors that had been attained may begin to recede. The other factor that is worthy of consideration at this juncture is the mobilisation of school nurses. At the time the research was conducted, it was clear that the potential of school nurses to support the scheme was not fully realised. The reasons for this were predominantly related to their employment arrangements. However, with the emergence of PCTs as employing organisations there may be opportunities - or further constraints - for greater involvement from school nurses. The situation is clearly a dynamic one.

Previous research indicates that young people and parents are typically the two stakeholder groups that are overlooked in healthy schools schemes (Aggleton et al, 2000; Moon et al, 1999). However, the Cheshire local programme established at an early stage a process for actively engaging young people. This led to their direct and ongoing involvement in the programme and was perceived to be a strength of the local scheme. There was also evidence of some schools taking steps to engage parents in the scheme. For example, a parent in one school in Cheshire was acting

jointly as the school co-ordinator. In another school, people from health promotion had developed a display about the NHSS for a parent's evening. These activities with young people and parents demonstrate that the local programme had started to establish partnership arrangements with key stakeholder groups.

The Cheshire healthy schools programme had success in respect of meeting its recruitment targets in a relatively short space of time, in a large and diverse county. The reasons for this success are likely to be many and varied. However, one factor relevant to understanding the development of the programme was a history of working together. Aggleton et al (2000) also identified that effective partnership work was likely to be characterised by the following: is inclusive of relevant stakeholders; found a means of engendering a common vision; worked with schools in a non-prescriptive way; worked in ways that demonstrated respect for each other's differing priorities. It is evident from the descriptions presented in chapters 4 and 5 that the Cheshire partnership developed over time. As the experience of working together and the pressure to perform well at the accreditation event increased, the commitment to a common vision also increased, as evidenced in the comments of interviewees. Similarly, the school process, as outlined in the Handbook, also contributed to a common vision, as well as setting out a non-prescriptive way of working with schools. People also reported working with schools in an empathetic way, centring on establishing relationships. These characteristics are consonant with the literature concerning the foundation of effective partnership work.

However, it is evident that the partnership experienced some difficulties, particularly at its initiation. This was, in large measure, because the national framework did not reflect the previous operational arrangements in the county; that is, it did not work with the grain of existing practice. One of the enduring issues was the role of outside agencies in the programme, particularly around delivery in the classroom. Green and Tones (2000) have pointed to the difficulties this poses for schools. Nonetheless, on the basis of the views expressed in the interviews, there is the potential to exploit further the considerable existing community resources to support schools in becoming healthy schools.

It was also evident that the context within which people were required to work posed considerable threats to effective partnership work. It was not that people expressed 'partnership fatigue' but rather fatigue with the volume of change. To this degree

then, the partnership was successful in the face of 'pressure' from a variety of contextual factors; factors which moreover were beyond any individual's control.

6.3 Conclusion

Glendenning (2002) proposes a definition for partnership working based on the notion of separate organisations choosing to identify, acknowledge and act upon common goals and interests. The NHSS represents a mandate for collaboration between the education and health sectors and therefore reduces the extent to which 'choice' can be said to be a factor in the development of the local partnership. However, on the basis of the evidence presented in this report, it is possible to conclude that the individual members of the Cheshire health and education partnership have worked within the framework of the goals and interests of the NHSS in the planning, management and delivery of the local programme. Partnership working is perhaps best evidenced at a micro level; that is, in the network of relationships that sustains the work of the steering group and locality groups, as well as at the interface with schools. In this sense then, it is possible to view partnership work as 'relationship building', reflected in the maturation of the partnership over time.

It was possible to identify a number of factors that enabled and militated against effective partnership work as discussed above. Achievements of the partnership were described against a background of complexity, change and uncertainty. Thus, partnership working appeared to be productive because individuals worked hard at it, sometimes against the grain of their local working context.

In conclusion, the NHSS can be described as a vehicle for innovation and change in some schools in Cheshire. However, it remains to be seen whether or not schools become healthy schools in a manner that leads to improved health and educational outcomes for children and young people. What can be said is that the local programme has been established in such a way that health and educational outcomes are being supported actively through the joint work of the health and education sectors. To this extent then, it is possible to conclude that the Cheshire healthy schools programme is a partnership based in health and education.

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Appendix 1

Interview schedule

Interview schedule

- Introductory comments: nature and scope of the interview; time available; permission to record.
- Perceptions of how the partnership arrangements were set up.
- Your role in relation to the Cheshire education and health partnership and the healthy schools programme.
- Views on the processes that underpin the planning, management and delivery of the healthy schools programme locally, including the setting up of steering group and locality groups.
- Role of outside agencies as potential partners in the healthy schools programme.
- Relationship of the local programme to other local initiatives and developments.
- Examples of 'working together' and what has enabled it.
- Factors that hinder people from working well together.
- Achievements of partnership(s) to date.
- Any other comments you would like to make?

Probes

- Could you give me an example of that?
- Could you say a little bit more about that?

Appendix 2

The sample of interviewees

List of interviewees by job title

Job title	Operational (O) and/or strategic (S) involvement ⁵	Member of Steering Group
LEA Advisor for PSHCE	S	✓
County NHSS Co-ordinator	S and O	✓
Health Improvement Co-ordinator with special responsibility for healthy schools (West)	O	
Health Improvement Co-ordinator (West) (2)	O	
Health Promotion Officer (Central)	O	
Principal Health Promotion Advisor (East)	S and O	✓
Health Improvement Manager (West)	S	✓
South Cheshire Health Authority Services Development Manager (Children's Services)	S	✓
School Nurse (West)	O	
School Nurse Manager (East)	O	
Secondary School Head Teacher (West)	O	
Primary School Head Teacher (West)	S and O	✓
Primary School Healthy Schools Co-ordinator (West) (2)	O	
Secondary School Healthy Schools Co-ordinator (East)	O	
Primary School Healthy Schools Co-ordinator (East) (with parent governor)	O	
Primary School Parent Governor (West)	O	

⁵ In this instance, the description of strategic or operational refers to involvement with the *partnership*.

Appendix 3

Membership of the steering group

Membership of the steering group

- Advisor for personal, social, health and citizenship education, LEA
- County healthy schools co-ordinator, LEA
- Detective Inspector for Community Affairs, Cheshire Constabulary
- Head of Specialist Health Promotion, East and Central Cheshire NHS
- Head teacher primary school, west
- County community and youth officer
- Service development manager, South Cheshire Health Authority
- Head teacher, primary school, central Cheshire
- Manager health improvement service, Chester and Halton Community NHS Trust
- Head teacher residential school, central Cheshire

Appendix 4

Personal statements about a Cheshire healthy school

Appendix 5

The School Process Model